Factors Affecting the Success of Intellectually Handicapped People Placed in Unsheltered Employment

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Abstract

This study aimed at providing some initial information about those variables associated with 'success' of intellectually handicapped people working in unsheltered jobs in New Zealand. Subjects were selected from clients of the local Branch of the New Zealand Society for the Intellectually Handicapped using vocational status and supervisor consensus. Two groups of 18 subjects each were compared on demographic, social and vocational variables while controlling for sex and secondary handicap. For one assessment instrument, it was also necessary to control for the independence of subscale pairs. Results indicated that further refinement of the Adaptive Functioning Index scales was required but that programmes designed to improve social problem solving ability and communication skills may aid in placing and maintaining trainees in unsheltered jobs.

The adherance to a client-centered placement procedure was advocated together with increases in the documentation of training programmes. These steps would allow the expansion of the present study to one with improved control procedures and wider scope.

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CHAPTER 1

Historical Antecedents

A characteristic feature of science can be seen in its emphasis on classification of phenomena into distinctive groups for systematic study. With the increasing attention devoted to social research in past years it is not surprising then that mental retardation came to be recognised as a pattern of social deviance distinct from for example, mental illness.

One of the earliest recorded distinctions between mental deficiency and mental illness was made in the time of Edward I, however the differentiation was largely administrative in nature, serving as it did, to define those people whose disability was permanent (the mentally retarded) and who as a consequence had their property and assets appropriated by the Crown, and those whose disability was relatively infrequent (the mentally ill) whose property was held in trust and run for them when they were incapable of it (Clarke and Clarke, 1974).

With the advent of industrialisation and the consequent movement away from smaller, home based family businesses to city based industries employing large numbers of people, the mentally retarded person became more of a family liability. It was no longer possible to easily supervise the handicapped person because as many people as possible were required to work to maintain the family. If one of the economic unit had to stay home to look after a handicapped sibling, it represented a significant loss of income. This situation resulted in number of mentally handicapped people being turned out of their family home (Maloney and Ward, 1979). Thus changing social conditions pre-empted the need for a change in the emphasis of the care of the mentally retarded. In the 19th century, a disease model was widely used in the orientation of care of mentally handicapped people, and this approach lead to the responsibility for the oversight of the mentally handicapped being given to the medical profession, a logical, if not entirely appropriate choice at the time.

From the beginning of this century an increased amount of attention was paid to the scientific aspects of mental retardion. Such attention

was not completely benefical. Darwin had recently published his evolutionary theory, and this coupled, with a popular approach to genetics lead to the belief that a population containing mentally retarded people would eventually (because of their promiscuity and poor control of basic drives) become tainted with inferior genes and hence show a progressive decline in characteristics thought desirable at the time such as moral principles, and intelligence. While this view changed later, even in the 1950's there was an identified sub-group of the mentally retarded classified as 'moral defectives' (Tregold and Soddy, 1956) and susceptible to sexual promiscuity if female and/or if male, petty crime. The development of this popular-view of mental retardation and its implications, was instrumental in the construction of institutions where people described as mentally retarded could be placed. Legal provision at this time (pre 1920) was concerned with the protection of society and this is reflected in the following passage from Fernald (in Sarason and Doris, 1969)

> "the feeble-minded are a parasitic, predatory class, never capable of self support or of managing their own affairs..... [they] cause unutterable sorrow at home and are a menace and danger to the community".

Fernald was one of the authors who contributed to the rise of the eugenics movement (Clarke and Clarke, 1974). At this point, definitions of mental deficiency were sufficiently loose to allow the incarceration of people with IQ's in the normal range. Clearly, there was a need to refine the criteria for classification, as the amount of subjective judgement involved in the 'mental deficiency' label was considerable and left the categorisation open to abuse, intentional or otherwise. At this time there were three main areas of attention in the endeavour to provide a meaningful definition of mental retardation. The first concentrated on the issue of social incompetence. However a definition centered on social incompetence was generally too vague,and so was still to a large extent arbitary (British Pschological Society, 1955). The second emphasised educational factors, that is, persistent educational failure, but once again was too wide as it is obvious that while educational failure may be primarily due to mental deficiency, it may also be due to other things such as a learning disability or unremediated visual problem (Wallin, 1949). The third is that of IQ.

The poor reliability of this category may arise from measurement error or factors due to individual tests. Also, cognitive growth does not necessarily happen in a constant pattern with reference to age peers. (Suran and Rizzo, 1979)

An attempt to achieve some order in terminology was made by the American Association of Mental Deficiency which convened a symposium in 1959. The definition that arose from this meeting (Heber, 1961) has become almost universally accepted in the mental retardation field (Craft, 1979).

Heber's definition reads as follows.

> "Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in one or more of the following: 1) maturation, 2) learning and 3) social adjustment."

The manual defines subaverage as more than one standard deviation below the population mean for age groups concerned, intellectual functioning in terms of 'objective tests', developmental period as childhood to 16 years, maturation in terms of rate of attainment of self-help skills, learning ability as the acquisition of achievements during school years, and social adjustment in terms of ability to maintain oneself in adult life in community living, employment and conformity to accepted standards. Throughout Heber's treatise it was emphasised that mental retardation as a label denoted current functioning of the individual without necessarily auguring permanent arrest.

Subsequent to the release of Heber's (1961) manual the meeting of the World Health Organisation Expert Committee (1968) opposed the term 'borderline mentally retarded' for the IQ group 68-85 (sixteen percent of the general population) and this has been removed from the classification levels. Thus IQ scores now have to fall below the second standard deviation of a standardised test to fall within the "retarded" range .

Concurrent to the rise of this altered definition, changes in society were occurring that would provide a climate for positive

revisions in lifestyle for many of the mentally handicapped. Factors that contributed to this attitude change included such things as the non-occurrence of the predicted national degeneracy, the discovery that genetic variation was more complex than at first suspected; the implication of environmental factors in some conditions and a generally more lenient approach to some forms of social deviance. Also, there had been a few successful programs run in institutions that suggested that the intellectually handicapped were capable of learning new skills (Clarke and Clarke,1974).

In the first half of this century, the provision of services for the intellectually handicapped was largely catered for within an institutional framework. The demand for these services was such, that often institutions were cramped and hence understaffed. Also, in a number of cases placement in an institutional facility was for life. This combined with the fact that institutions for the intellectually handicapped were often built in isolated areas often meant that an individual placed in an institution had very little exposure to society.

Although the process has been gradual, the preceeding two or three decades has seen a change from emphasis on institutional,to community services. Not only is this arrangement better economically, but it also acknowledges the fact that residence in a hospital-type situation is neither necessary nor desirable for the greater proportion of intellectually handicapped people. The percentage of people needing nursing care which can only be provided in a hospital is a relatively small proportion of the handicapped population. However, even now there are people who question the advisability of discharging some of the intellectually handicapped from institutional care. Graham, (1976) contends that any institution catering for intellectually handicapped people have a responsibility to ensure that discharge from institutional care will result in an improved lifestyle for those discharged . He reiterates the concerns of others in the area, saying that small homes for the handicapped within the wider environment of the community do not guarantee a greater level of 'normalisation' than the institutional villa. The prime consideration when making the decision to discharge or not, should be to make a client-centered judgement based on a number of questions, such as a) what constitutes a full life for the handicapped person; and b) what elements of everyday life contribute to this full life.

It may be that if the elements of a full life are available both within and outside of the institution, then no appreciable advance in normalisation will be gained from community placement.

The process of returning (or maintaining) developmentally disabled people to a community based lifestyle and the integration of them into patterns of behaviour as culturally normative as possible has been generally subsumed under the rubric of 'normalisation'. Normalisation can most comprehensibly be defined in terms of 'rhythm of life' (Wolfensberger, 1972). This involves encouraging the handicapped person to maintain a lifestyle compatible with the culture around him. Introduction of the normalisation principle is seen as most easily implemented in facilities that cater for smaller numbers of people and so have a favourable staffing ratio, and better similarity to a 'family' situation.

In practise, there are problems with normalisation, not the least is defining what 'normal' is and the difficulty of conducting training programs that allow sufficient spontaneity to develop hence guarding against the dangers of teaching overly complaint behaviour. There is also the question of who is to undertake the training, and the development of support services that widespread adoption of the normalising process will need. The choice is basically between a government or voluntary agency orientation or some combination of the two.

In New Zealand, the majority of social, residential and vocational services for mentally handicapped people are provided by the New Zealand Society for the Intellectually Handicapped (Inc.), the growth of which will be traced in the following section.

Services in New Zealand

This section will briefly review the development of services for an intellectually handicapped person in New Zealand, and concentrate on the growth of the principle agency involved with provision of facilities for the developmentally disabled population, the New Zealand Society for the Intellectually Handicapped. This does not mean that it is the sole agency in the area. There are religious organisations, such as 'Marylands' run by the Brothers of St. John of God, a Catholic order, and facilities like the Hohepa Homes in Hawkes Bay, who subscribe to the Rudolf Steiner philosophy. However, these private agencies account for a very small proportion of habilitation services.

As early as 1892, it was recognised that there were children in the regular classroom who were misplaced because of the extent of their poor academic performance. The emphasis at this time appeared to focus mainly on the detrimental effect these underachievers or 'backward' children were having on the other memebers of the class, however, little was done to bring about understanding of the problem (Wenzell, 1965).

In 1896 two school inspectors suggested using a local Girl's school as a special school for backward children, but this suggestion was not implemented. The problem was in part recognised in 1899, when the then Minister of Education gave headmasters discretionary power to group pupils in different classes according to their respective abilities but it was not until 1908 that the growing awareness of a need for services in the schools for slow learners became action. The first school was established in this year for these children in Otago and catered for boys ranging in age from 7 to 16 years. It was not until 1916 however that a residential school for girls was opened near Nelson.

By 1919 the Department of Education endorsed the view that every large school ought to have a class for the 'subnormal' - and from this time there was an increase in the number of special classes. However progress was slow and by 1923 only 9 schools in New Zealand had established a special class. This unfortunate lack of classes hindered the development of the relationship between the pupils, parents and classes proposed by the Minister of Education in 1919 who had stated that through

the establishment of special classes, it was hoped to cater adequately for all 'feeble-minded' children in such a manner that will permit the majority of them to remain in their homes, under the supervision of qualified officers who will keep in close contact with them and will assist in placing the children in suitable employment when the proper time arrives (Wenzell, 1965).

At this stage in the development, services were concentrated on the 'educable' handicapped population. Very little was provided for those regarded as incapable of learning (the moderately, severely and profoundly retarded) other than provision for hospitalisation in large institutions. In this respect New Zealand closely paralleled most other countries.

Along the path to community care for intellectually handicapped people was the Social Security Act of 1938. This, was a wide and sweeping declared committment on the part of the government to provide welfare within the community, funded entirely from taxation. The policy of the Act was to provide for payment of benefits designed to safeguard the people of New Zealand from disabilities arising from varied conditions, so as to promote the general welfare of the community (Matthews, 1972).

In response to the continuing need for community based services for intellectually handicapped people, and governmental inaction, a parent association was formed in 1949 as a presssure group to gain government support. As a result of efforts by this group, the government agreed in 1953 to establish special schools to cater for children with lower I.Q. levels and to subsidise running costs and in 1963 the minimum roll for these schools was reduced to five. Between 1960 and 1973 the Society received increasing financial support from Government towards the capital cost of establishing its services, and a small subsidy toward operating junior hostels. Also during this period, the first pre-school facilities were opened (1960) and the first Workshops for adults started (1962 approximately). In 1962 the association became the Intellectually Handicapped Children's Society a title that was subsequently revised to its present form in 1975.

In 1967 the Government provided for the Society's work to benefit under a new rehabilitation program for the disabled. Under this programme, the Society was given subsidy assistance towards the cost of salaries paid to its pre-school, special care centres and workshops.

1970 saw the establishment of a Royal Commission to report on Hospitals and Related Services. The Society's submissions urged that services for the intellectually handicapped should be dispersed throughout New Zealand, adjacent to the family and its community, and be provided in small local units. The Royal Commission agreed with these proposals and a recommendation along these lines was made to Government. In 1974, the Government accepted the Commissions recommendation and recognised that in economic terms provision of the services needed by intellectually handicapped children and adults could be provided at a much lower cost through community based agencies such as the Society. As a guide to the respective costs incurred, in 1976, the cost of maintaining a handicapped person in a Hospital Board Institution was approximately $140.00 per week, as opposed to $55.00 a week in a similar bed in the Society's hostels (N.Z.S.I.H., 1977).

In 1974 an agreement between the Hospital Boards and the Society provided for a) residential and Workshop services to built by the Hospital Boards and made available to the Society to operate, to cater for people in institutional care who could be expected to successfully live in the community and b) that the Government provide additional funding and staff training assistance to help the Society meet the increased demands.

The Philosophy and Policy booklet (1979), published by the Society, in paragraphs 17-21 outlines in general terms the various services needed by the intellectually handicapped person and their families to facilitate their development to the maximum possible. To date the Society, in 32 Branches caters for some 2,653 adults in 74 Worksops and Rural Training Units, 523 children in 44 pre-school and junior centers, and maintain 184 Residential facilities of all types. In addition to the aforementioned services, other needs are met as follows.

For infants and young children, a consultant Paediatrician service is provided for a limited number of hours per month. The paediatrician

receives a retainer from the Society, and no charge is made to the parent. Also, home support programs are available, under which staff with special training in education, social work and 'para-medical' skills visit the home to help and advise the parents. School age children, who have not been accepted into special schools run by the Education Boards, are able to attend special care services. Adults are served, not only by the numerous sheltered Workshops, but also by the organisation of social and recreational programs aimed at developing their personality, and promote their physical health. These aid in the integration of the handicapped person into the surrounding community.

In a corporate capacity, the Society fills the need for an advocate for the general rights of the intellectually handicapped in the community. Because of the nature of their handicap few mentally retarded people can effectively obtain all the benefits and services to which they are entitled or press for these rights to Government bodies.

In conclusion then, New Zealand is one of the few countries where a non-Government community based agency delivers the major part of the services for the developmentally disabled. In most other countries, the community agency mainly accepts the responsibility of being an advocate for the general and individual rights of the intellectually handicapped combined with some innovative work in aspects of services which once proven worthwhile, is transferred to a Government Department for widespread implementation.

There are advantages and disadvantages to this situation. For example, the absence of bureaucratic 'red-tape' enable a response to perceived needs to be initiated with greater rapidity and flexibility, however, the lack of a steady cashflow and relatively high dependence on volunteers make forward planning difficult.

The situation at present is not static - both the Government and the Society are continuing to revise and adapt the relationship that exists between them to improve efficiency and cost effectiveness.

Rapid growth in services has been paralleled by an increasing demand. The resulting pressure on the Society for places in facilities has accentuated the need to evaluate the utility of social and vocational

training programmes. One of the most valid methods of gauging effectiveness of programmes is to examine outcome of training in terms of personal competancies and life skills, (Gunzburg, 1973) especially to note the proportions of individuals who have been able to 'graduate' to the community.

Responding to this need for information on programme effectiveness, this present study was undertaken to initiate the development of comprehensive training guidelines, so that the facilities of the N.Z.S.I.H. (IHC.) can provide the instructional programming to maximise the potential of their clients. For some clients, the ultimate result of their attendance at the Workshops, will be progression to unsheltered jobs.

There are problems, however, with this type of evaluation (for example varied research design) not the least of which is the definition of adequate criteria of success of placement in unsheltered jobs. In the next section, an attempt is made to review the literature and define criteria for the selection of successful and non-successful subjects.